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NOT TO BE PUBLISHED IN THE OFFICIAL REPORTS

IN THE COURT OF APPEAL OF THE STATE OF CALIFORNIA

SECOND APPELLATE DISTRICT

DIVISION ONE

DAVID K. CUNDIFF, Petitioner and Appellant, v. MEDICAL BOARD OF CALIFORNIA, Respondent.	B234734 (Los Angeles County Super. Ct. No. BS126568)

APPEAL from a judgment of the Superior Court of Los Angeles County, James C. Chalfant, Judge. Affirmed.

David K. Cundiff, in pro. per., for Petitioner and Appellant.

Kamala D. Harris, Attorney General, Carlos Ramirez, Senior Assistant Attorney General, Robert McKim Bell, Supervising Deputy Attorney General, and Klint James McKay, Deputy Attorney General, for Respondent.

In 1998, relying on erroneous information, petitioner and appellant David K. Cundiff, M.D. withdrew anticoagulant medications from a patient who had tested positive for deep vein thrombosis in a proximal vein. The patient subsequently died as the result of a pulmonary embolism. Cundiff was found grossly negligent and incompetent in his care and treatment of the patient, and his medical license was revoked. Cundiff has always maintained that his decision to withdraw anticoagulants for the patient who died was correct.

In 2010, an administrative law judge denied Cundiff's request for reinstatement of his license on the ground that he failed to demonstrate sufficient evidence of rehabilitation to merit reinstatement. Cundiff then filed the underlying petition for writ of administrative mandate seeking to set aside the order denying reinstatement. The trial court denied Cundiff's petition. We affirm.

FACTUAL AND PROCEDURAL BACKGROUND

Precipitating events and license revocation

Cundiff was licensed in 1977 by respondent Medical Board of California (Board) to practice as a physician and surgeon. Cundiff is board certified in internal medicine, medical oncology and hematology (a medical subspecialty diagnosing and treating bleeding and clotting disorders). The Board revoked Cundiff's medical license in September 2000, after accusations of gross negligence and incompetence were sustained against him in connection with his care and treatment of a patient known as "B.R." in February 1998. The now undisputed facts of B.R.'s case are as follows:

On the evening of February 6, 1998, B.R., a 59-year-old man, was brought to the emergency room at Pomona Valley Hospital (Pomona Valley) by his adult daughter. B.R. complained of pain and numbness in both legs and experienced difficulty walking, symptoms which had worsened over the preceding two weeks. For about a month, B.R. had also had a cough with productive sputum. A venous duplex scan taken of B.R. was positive for deep vein thrombosis (DVT) in the right popliteal vein. He was diagnosed with triple pneumonia, DVT and possible tuberculosis (TB). 5,000 units of the

anticoagulant Heparin was administered intravenously to B.R. B.R., who lacked health insurance, was transferred to Los Angeles County/USC (LAC/USC) hospital.

Records prepared for B.R. at Pomona Valley inaccurately stated he had a history of homelessness for the preceding 10 years, and had been living on the street for two months. Records prepared upon B.R.'s admission to LAC/USC contained further inaccuracies, including indicating (falsely) that he was homeless, and had experienced a 30-pound weight lost in the past month. At about 8:00 p.m. on February 7, 1998, B.R.'s history was recorded by Dr. Karunananathan. She wrote that B.R. had experienced a 50-pound weight loss in the past two months, but did not record B.R.'s weight. She also wrote that B.R. was unemployed and had consumed one six-pack of beer per day for 20 years, but quit drinking six months earlier. Karunananathan also said B.R. was homeless, although she later crossed out that statement and wrote "has home." At an administrative hearing in May 2000 Administrative Law Judge (ALJ) Stuart Waxman (the Waxman hearing), Karunananathan testified that she obtained the information she included in B.R.'s history directly from B.R.

B.R.'s daughter, a substance abuse counselor who maintained a close relationship with her father, disputed the veracity of a number of entries in her father's medical history. She claimed that B.R. drank "considerably less" than a six-pack per day, and had not ceased drinking before he was hospitalized. The daughter also testified that B.R. had been employed as a cook in the same fast-food restaurant for many years, where he continued to work until his hospitalization.

Karunananathan confirmed B.R.'s diagnosis of DVT, continued the Heparin at 1000 units per hour. At 7:30 a.m. on February 8, Karunananathan increased B.R.'s Heparin to 1200 units per hour, then shortly thereafter decreased it to 1100 units per hour and ordered that B.R. be given 5 milligrams per day of Coumadin, another anticoagulant (also known as Warfarin), administered orally.

In February 1998, Cundiff was an attending physician, and served as the supervisor of interns and residents, at LAC/USC. As such, he was responsible for

hearing all new patient presentations made by his "house staff." He generally supervised two interns, a first-year resident, a senior resident and between one and four students. He met with his team daily. Cundiff was also supposed to read and cosign the interns' and residents' notes every 48 hours, but was too busy to do so, and never saw all his patients' charts within a given 48-hour period.

Cundiff was not on duty the day B.R. was admitted to LAC/USC. When Cundiff returned to duty on February 9, he was briefed about B.R.'s history and condition by his team, which included Karunananathan and Dr. Harake, to whom B.R. had been assigned. Cundiff recalls having been told, among other things, that B.R. was 59 years old, with TB and DVT, and that the patient was unemployed, had a history of homelessness and had been transferred to LAC/USC. Cundiff understood that B.R. was presently homeless and an alcoholic. Cundiff did not personally review B.R.'s records from Pomona Valley or the film of his duplex scan. He read the emergency room notes, Karunananathan's history and physical of the patient and progress notes from February 8, and counter-signed Karunananathan's order for Heparin and Coumadin. Cundiff signed B.R.'s chart just twice during the patient's 12-day hospitalization.

At 6:00 p.m. on February 9, based on a recommendation by the hospital's "Anticoagulation Team,"[1] Harake increased B.R.'s dose of Heparin to 1300 units per hour.

On February 9, Cundiff's workload only permitted him the time to conduct a partial examination of B.R. He ordered Coumadin again (which had not been given, although ordered by Karunananathan). Cundiff was concerned about the risks of the medicine, but considered anticoagulation standard treatment for popliteal DVT. That same day, a member of the Anticoagulation Team found B.R. to be "sub-therapeutically

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[1] The Anticoagulation Team was composed of clinical pharmacists who could, but need not, be consulted by hospital physicians for help determining the proper dosage and efficacy of patients' anticoagulant medications.

anticoagulated," and recommended that the Heparin dosage be increased to 1400 units per hour and that 5 milligrams of Coumadin be given that night; both recommendations were implemented by the physician in charge.

On February 10, B.R.'s chart reflected that a radiologist reviewed the ultrasound taken at Pomona Valley, which revealed the presence of a thrombosis (blood clot) in the right popliteal vein. B.R. continued to receive 1400 units per hour of Heparin. A member of the Anticoagulation Team, who determined B.R.'s INR (a measure of liver function) was stable, also recommended increasing Coumadin to 7.5 milligrams.

On February 11, Cundiff unilaterally decided to discontinue both Heparin and Coumadin for B.R., and so instructed his team. The only reason recorded in B.R.'s chart for Cundiff's decision to cease using anticoagulants was the location of the thrombosis in the popliteal vein. Cundiff did not discuss the reasons for his decision with his team and, with the exception of one team doctor (whom ALJ Waxman did not find credible on this point), no one recalled Cundiff mentioning any reason for his decision to discontinue both medications apart from the location of the thrombus. Cundiff did not order any alternative DVT treatment for B.R., such as a vena cava ("Greenfield") filter. Neither Cundiff, nor any member of his team, discussed the matter with B.R. or his daughter, nor did they verify the accuracy of Cundiff's perception of the risk factors B.R. presented, or obtain B.R.'s consent to discontinue the anticoagulant medications. If they had done so, Cundiff would have learned B.R. was neither homeless or unemployed, and that he drank less than two quarts of malt liquor per day on weekends.[2] Cundiff testified that he did not discuss his decision to discontinue anticoagulants with his patient because B.R. "was not emotionally, psychologically or educationally capable of understanding," but he did assume his team had discussed the issue with B.R. and his family. ALJ Waxman found that Cundiff's "decision to discontinue anticoagulants on February 11 was an extreme

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[2] The record does not indicate how much, if any, alcohol B.R. consumed on weekdays.

departure from the standard of care and constituted both gross negligence and incompetence."

On February 18, B.R. developed respiratory depression and a rapid heart rate and was transferred to the ICU. On February 19, at 5:30 a.m., B.R. "coded" but was resuscitated. By 12:30 p.m. B.R. was "'non-responsive, paralyzed and sedated,'" and his condition was deemed critical. At about 1:00 p.m., B.R. underwent an emergency pulmonary arteriography to rule out a pulmonary embolus. Bilateral emboli were present. Large and extensive emboli in the right pulmonary artery permitted only minimal right lung perfusion, and decreased blood flow to the left upper lobe was consistent with preexisting destruction due to TB. Several efforts at suction embolectomy resulted only in removal of a small amount of the clot from the right lung. B.R. developed a low heart rate and low blood pressure during this procedure, and died at 2:45 p.m. An autopsy reflected that the cause of death was "pulmonary embolism due to [DVT] due to disseminated [TB]."

Throughout his hospitalization, B.R. was consistently described as "'oriented to time, place, name,'" and "'interactive, calm and cooperative'" with "'memory & expression within normal limits.'" Nothing in B.R.'s records indicates he was ever noncompliant or uncooperative, refused any medications offered or that staff members had trouble communicating with him. B.R.'s daughter visited her father daily during his hospitalization, but was largely unsuccessful in her attempts to speak with members of his medical team, and never spoke to Cundiff.

In early March 1998, Cundiff told his supervisor, Dr. David Goldstein, that his decision to stop B.R.'s anticoagulant medications was "controversial" because of the location of the popliteal vein (generally, anticoagulants are deemed unnecessary if a thrombus is below the knee). Even after Goldstein showed Cundiff illustrations demonstrating that the popliteal vein extends above the knee, Cundiff failed to offer any different or additional explanation for his decision. Because Cundiff offered only an anatomically-based reason for his decision to stop the anticoagulants, Goldstein believed

Cundiff's decision had been premised on an anatomical error. Goldstein did not ask Cundiff why he did not used an alternative anticoagulant therapy such as a Greenfield filter because, if Cundiff believed the popliteal vein was located below the knee there would have been no reason to use the filter. Cundiff testified that he and Goldstein had a "'long, uncordial history of grievances'" which had caused friction between them. Cundiff also believed Goldstein was in a hostile, argumentative mood during their meeting, and that it would have been unproductive to explain the other reasons for his decision. At the Waxman hearing, Cundiff conceded that, at a hearing in 1999, he testified he told Goldstein his decision had been due to "a combination of several factors and . . . was a complex, controversial call." Cundiff also said he was not aware that the popliteal vein was a proximal vein, and said the popliteal vein was "arbitrarily grouped with the proximal veins."

A three-member peer review committee found that Cundiff's care and treatment of B.R. fell below the standard of care. Cundiff was discharged from LAC/USC. An evidentiary hearing was subsequently conducted by a civil service hearing officer, who affirmed Cundiff's discharge, and his license was revoked.

At the Waxman hearing in May 2000, Cundiff claimed he discontinued B.R.'s anticoagulants in February 1998 because he was concerned from the outset about the risk of bleeding due to the fact that B.R. suffered from anemia (had a hemoglobin reading of 9.7), and his liver function was severely impaired. Neither factor was an absolute contraindication, but each was major risk factor. Cundiff was also concerned because he believed B.R. was homeless, unemployed, an alcoholic and suffered from malnutrition. As such, Cundiff believed B.R. would not follow through with necessary monitoring of his anticoagulant medication after being discharged, especially because he would not be able to afford the $40 per visit clinic fee or transportation to and from the clinic, and there was no follow-up for patients who missed appointments. In Cundiff's opinion, those

factors, coupled with the chance that B.R. was likely to fall down due to his alcoholism, placed B.R. at "extremely high risk for bleeding."[3]

Cundiff realized the popliteal vein is a proximal vein and that clots in proximal veins are typically treated with anticoagulants to reduce the risk of a pulmonary embolism. He also knew "anticoagulants are generally not used to treat clots in distal veins even though there is a slight risk of death from a clot in a distal vein." Cundiff said it was a matter of "'gradation'" and that the popliteal vein was the most distal of the proximal veins, so the risk of pulmonary embolism is lower in that vein than in other proximal veins. He believed that B.R. presented a greater risk for bleeding than of suffering a pulmonary embolism. He prescribed the same treatment generally prescribed for patients with superficial phlebitis (warm soaks, elevation of the leg, pain medication and mobilization), a condition less serious than DVT.

Following B.R.'s death and revocation of his medical license, Cundiff conducted extensive research from which he concluded that there is no scientific validation for the proposition that anticoagulants decrease the chance of death in a popliteal DVT. As a result, at the Waxman hearing, Cundiff was even more convinced than he had been at the time B.R. was under his care that he made the correct decision and said he would "undoubtedly make the same decision again if faced with the same situation today."

ALJ Waxman found Cundiff's stated reasons for not discussing his decision to discontinue anticoagulant treatment with B.R. or his family not credible. Even if Cundiff had not believed B.R. capable of understanding that decision, there was no reason Cundiff could not have discussed the matter with his patient's family. Further, if Cundiff

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[3] Cundiff's decision was also affected by a new patient he saw on February 11, shortly before deciding to discontinue B.R.'s anticoagulant medications. The new patient, who was being treated with Coumadin, lacked medical insurance and chose not to pay the $40 per visit clinic fee to monitor his medication. As a result, his Coumadin level was not maintained at a therapeutic level and the patient was lucky not to have bled. After discussing the matter with the patient's regular physician, Cundiff decided to discontinue the patient's Coumadin until he obtained insurance.

believed that both B.R. and his family were incapable of understanding the reasons he had decided to discontinue the anticoagulant treatments, it would have been illogical for Cundiff to also have believed that his team had discussed those same matters with them. Moreover, Cundiff testified that, in the few interactions he did have with B.R., the patient's responses to his questions were short, but appropriate. Accordingly, Waxman found Cundiff had not established a basis for his purported belief that there was no need to discuss, or would have been no point in discussing, his decision to discontinue anticoagulant treatment with B.R. or his family.

Cundiff recognized that there was a risk of propagation and acknowledged that a clot larger than the aperture of a Greenfield filter was unlikely to travel beyond the filter. However, he chose not to install a filter in B.R. because he believed it increased the risk of thrombosis, tearing and other complications, and because he considered such filters unproven with respect to their ability to reduce the risk of mortality. Cundiff acknowledged that the "Merck Manual" recommends use of such a filter. Without seeing the data however, Cundiff informed ALJ Waxman he was unwilling to accept that manual's representation that the complication rate is low if filters are used.

For over a year after B.R.'s death, the only reason Cundiff offered for his decision to discontinue B.R.'s anticoagulants was the location of the clot in the popliteal vein. He never identified any other reason in B.R.'s chart, nor did he provide any other explanation for that decision to either Goldstein or the officer who conducted the initial civil service hearing. Indeed, it was not until a hearing in April 1999, over a year after B.R.'s death, that Cundiff identified any factor other than the location of the thrombus as a basis for his decision. ALJ Waxman found the testimony regarding Cundiff's belated mention of other factors which purportedly were part of his initial risk/benefit analysis to be of "dubious credibility."

At the Waxman hearing, both Cundiff and the Board offered expert witness testimony. Cundiff's expert, Dr. Michael Conolly, testified that Cundiff's conduct had not fallen below the standard of care because "the risks of anticoagulation outweighed its

benefits in B.R.'s case." If B.R. had been discharged and prescribed Coumadin, the most significant risk he would have faced would have been his own failure to show up at the clinic for monitoring. Because Coumadin has a narrow therapeutic range, B.R.'s failure to undergo proper monitoring could result in uncontrollable bleeding. This was particularly significant because anticoagulation therapy had not been proven an effective treatment for DVT in the popliteal vein. It was also unnecessary to order a Greenfield filter as an alternative treatment because there were potential complications associated with that treatment, and it too had no guarantee of effectiveness. Nothing was done after February 11 for B.R. to protect against pulmonary embolism because nothing was called for as the thrombosis was localized in the popliteal vein.

In Conolly's opinion, Cundiff provided appropriate medical treatment to B.R. Conolly acknowledged that, "'in a perfect world,'" a physician would double check the factors underlying his decision, read a patient's chart himself rather than relying on representations made by interns or residents, and discuss his actions and decisions with his patient. However, Conolly said that, "'in the real world'" there was simply insufficient time for a doctor to double-check all facts or read the charts, and that "sometimes the issues are simply too complex," so it is "necessary to protect patients from themselves."

The Board's expert, Dr. Albert Yellin, testified that Cundiff's decision to discontinue anticoagulants for B.R. was "'emphatically below the standard of care and practice for physicians in this community.'" Yellin testified that it was "'incontrovertible'" that DVT is potentially fatal and that popliteal DVT is a deep vein disease. He said a risk/benefit analysis is always appropriate. But, in the absence of an absolute contraindication, anticoagulants must be initiated and continued for at least three months. Standard practice dictates that, if a patient cannot be anticoagulated, a Greenfield filter should be installed to prevent a clot from traveling to the heart or a lung. Vena cava filters pose very low risk and have proven to be over 90 per cent effective. In Yellin's opinion, Cundiff and Conolly conducted a "'selective review of the literature' in

order to arrive at their conclusions" which were equivalent to declaring that "'the Earth is flat.'" According to Yellin, the "'overwhelming conclusion' in the literature is that DVT, including popliteal DVT, must be treated with anticoagulants for three months or, in the alternative, a vena cava filter must be used."

In his review of B.R.'s case, Yellin found no reason to discontinue anticoagulants. B.R.'s chart contained evidence of symptoms consistent with a patient with TB, which were reasons to carefully monitor him, but not to discontinue anticoagulants. B.R.'s chart also contained references to the popliteal vein as a "'superficial'" vein which, in Yellin's opinion, was a "'gross misstatement.'" The popliteal vein, the diameter of which is "approximately the size of a man's fifth finger," is part of the deep venous circulatory system and "carries 85 [percent] of the blood back to the heart." The "popliteal vein is a proximal vein" (as are the veins above the popliteal vein). The standard of care calls for treatment of "thrombosis in proximal veins . . . with anticoagulants because proximal veins give off large [clots] that are more likely to be fatal than the smaller [clots] that tend to come from the distal veins."[4]

According to Yellin, pulmonary embolisms are common; more than two million patients develop DVT each year. Of those, 600,000 suffer a pulmonary embolism, 10 percent of which are themselves fatal or a contributing factor in a patient's death. More people die each year as a result of a pulmonary embolism than die from breast cancer. But, "the risk of death from hemorrhage[ing] while on anticoagulants is less than [one] or [two percent]."

Yellin noted that Cundiff claimed to believe B.R. was homeless, anemic and an alcoholic suffering from liver disease, and testified those factors were contraindications for continuing the patient on anticoagulants. In Yellin's opinion it was improper to assume that every homeless person would be noncompliant. The fact that someone was

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[4] "[D]istal veins are the small veins located below the popliteal vein between the ankle and calf" and "lead to the popliteal vein."

homeless would legitimately raise the level of concern, but would not constitute a reason to discontinue anticoagulants. In addition, B.R.'s chart contained no evidence that he had been an alcoholic. If B.R. been a heavy drinker for 20 years as Cundiff believed, his liver would have shown signs of cirrhosis; an autopsy of B.R.'s liver revealed no conditions consistent with cirrhosis. Yellin also said Cundiff's decision not to discuss his decision to discontinue anticoagulants with B.R. because he believed his patient was unqualified and unable to understand the risk/benefit analysis, was "'paternalistic.'"

Of the two medical experts who testified, ALJ Waxman found Yellin more credible and persuasive for four reasons. First, and most tellingly, notwithstanding his testimony that anticoagulants had not been proven to be effective, Conolly used them to treat all his own patients with DVT (unless absolutely contraindicated), but failed to explain why he continued to do so if anticoagulants posed such an unacceptable risk.[5] Second, Conolly is an internist whose primary focus is on pain management; he sees three or fewer DVT patients per year. Yellin is a surgeon who has authored articles, book chapters and audio tapes on DVT. He has treated "'hundreds, if not thousands'" of patients suffering from venous thrombosis. Third, Conolly saw nothing in B.R.'s chart to indicate that the patient had been noncompliant, mentally impaired or had had any difficulty understanding English. Fourth, Conolly accepted Cundiff's explanation for his decision to discontinue B.R.'s anticoagulant medications at "'face value,'" even though Conolly saw no explicit reason for that decision noted in B.R.'s records. ALJ Waxman also noted that the consensus among the physicians who testified at the hearing, including Cundiff, was that "it was medically likely" that discontinuing "the anticoagulants caused the pulmonary embolism which resulted in B.R.'s death."

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[5] According to Conolly, based solely on a lack of evidence of any proven effectiveness and the risk of bleeding in any given patient, the risk would always outweigh the benefit in every patient and "any increased risk would only serve to make a physician more certain that anticoagulation is an inappropriate treatment."

ALJ Waxman concluded that, as B.R.'s physician, Cundiff had a duty to be fully familiar with factors relevant to his patient's care. He failed to fulfill that obligation by failing to read B.R.'s (noticeably thin) chart completely, failing to review the duplex scan taken at Pomona Valley, and relying entirely on verbal representations of his interns and residents for information vital to B.R.'s care and treatment. In addition, Cundiff based a "life and death decision" on erroneous information that could readily have been clarified, enabling Cundiff to make an intelligent and informed decision regarding treatment of B.R.'s DVT, had he simply discussed his concerns with his patient (who appeared able to converse and answer questions appropriately), or his patient's family. ALJ Waxman acknowledged that Cundiff maintained a hectic workpace in February 1998. Nevertheless, the fact that Cundiff was extremely busy was no excuse for the improper treatment B.R. received. Moreover, by Cundiff's own admission, he failed to discuss treatment options with B.R. not because he was too busy to do so, but because he believed (unjustifiably) that his patient was not capable of understanding the issues involved.

ALJ Waxman noted that it was difficult to determine whether Cundiff made his decision to discontinue B.R.'s anticoagulants after conducting a risk/benefit analysis, or whether he simply made an anatomical error regarding the location of the popliteal vein. Regardless of which explanation obtained, ALJ Waxman found that Cundiff's decision fell below the standard of care.

If Cundiff's decision was premised on a risk/benefit analysis, based on what he believed was B.R.'s homelessness, alcoholism, lack of employment and potential non-compliance, the decision had simply been an illogical one. In light of the fact that as many as 60,000 of the 600,000 people who suffer pulmonary embolisms from DVT die each year, Cundiff chose to place his patient at considerable risk based on a belief that "B.R. *might* be non-compliant, *might* not go to a clinic for regular monitoring and *might* fall down, any one of which *might* cause" him to suffer an uncontrollable bleed if he was

taking Coumadin. Cundiff's decision was also particularly illogical in the absence of a reasonable alternative treatment, such as placement of a vena cava filter.

On the other hand, if Cundiff's decision was based on an anatomical error—a belief that anticoagulants were not necessary for a thrombosis in the popliteal vein because that vein was located at or below the knee—by all accounts (other than his own and Conolly's), Cundiff was simply wrong. The evidence showed that the popliteal vein is a proximal vein capable of propagating a large clot, and the proper treatment for DVT in the popliteal vein is anticoagulation.

On the evidence presented, ALJ Waxman concluded that Cundiff's decision was based on an anatomical error, in that Cundiff believed the popliteal vein was sufficiently distal to present an acceptable risk of pulmonary embolism in the absence of anticoagulant treatment. ALJ Waxman reached that conclusion based primarily on the facts that Cundiff:

1. Failed to mention that he had conducted any risk/benefit analysis to anyone for more than a year after B.R.'s death;

2. Failed to discuss his risk/benefit analysis with his team members, B.R. or B.R.'s daughter;

3. Initially approved use of both Heparin and Coumadin for B.R.;

4. Failed to chart any reasons for discontinuing the anticoagulants apart from the location of the clot;

5. Did not consider using a vena cava filter (which would not have been a necessary measure for a distal DVT or a superficial phlebitis); and

6. Ordered only an alternative treatment consistent with that generally prescribed for superficial phlebitis.

Based on his factual findings, ALJ Waxman found cause to revoke Cundiff's license on the ground that he had been grossly negligent and incompetent in his care and treatment of B.R. (Bus. & Prof. Code, §§ 2227, 2234, subds. (b), (d).)

ALJ Waxman noted that the purpose of administrative proceedings was "to protect the public from errant practitioners," not to punish licensees. Ordinarily, in a case involving a single patient and a licensee like Cundiff, who had practiced medicine since 1977 and had no disciplinary record, revocation of a medical license would be unwarranted. Here, however, revocation was in order because Cundiff presented an even greater risk to prospective popliteal DVT patients in 2000 than he had before. ALJ Waxman observed that, at the time of B.R.'s death in February 1998, Cundiff was convinced he made the proper treatment decision. Since that time Cundiff had devoted over two years to researching the issue. Based on that research, Cundiff concluded that, "because of the lack of effectiveness of anticoagulation in the treatment of popliteal DVT, he [had been] absolutely correct in discontinuing anticoagulants . . . ." However, ALJ Waxman observed that Cundiff's conclusion was "completely at odds with the mainstream thinking of practicing physicians and researchers in the community." ALJ Waxman further noted that it was "unacceptable for a physician to completely disregard the standard of care in the community simply because he (and very few, if any, others) believe[d] the literature [did] not support it, [and] to then discontinue the very treatment called for by the standard of care, and to fail to offer any effective alternative treatment."

ALJ Waxman noted that Cundiff had "made it very clear at the administrative hearing that, if faced with the same situation [in the future], he would make the exact same decision" he had made in B.R.'s case. Given the fact that over two million patients suffer DVT every year, ALJ Waxman found that popliteal DVT patients who might be treated by Cundiff faced an even greater risk of pulmonary embolism than B.R. had faced, based on Cundiff's now firmly held belief that the standard treatment for that condition, accepted by the vast majority of the members of his profession, was "nothing more than 'dogma.'" As a result, ALJ Waxman found that the risk to the public if Cundiff were to be permitted to continue to practice medicine was too great, and that no probationary order could adequately address or protect the public from that risk.

The Board adopted ALJ Waxman's decision and Cundiff's medical license was revoked in September 2000.

Petition for reinstatement

In March 2009, Cundiff filed a petition with the Board seeking reinstatement of his medical license, pursuant to Business and Professions Code sections 2221 and 2307. Cundiff's petition was premised primarily on his contention that testimony given by B.R.'s daughter in a deposition taken after September 2000 contradicted her testimony during the 2000 Waxman hearing about whether her father was an alcoholic, and also raised questions about the credibility of B.R. and his daughter regarding B.R.'s employment status and whether he had been homeless. Cundiff also claimed to have sufficient evidence of "rehabilitation" to demonstrate an entitlement to reinstatement of his license. A hearing on Cundiff's petition for reinstatement was conducted by ALJ Daniel Juárez in January 2010 (Juárez hearing).

During the Juárez hearing, Cundiff made numerous attempts to explain his actions in the case of B.R., to introduce evidence to establish that certain factual findings made during the Waxman hearing were inaccurate, and to introduce evidence of research conducted since his license revocation to establish that his actions in 1998 had, at least arguably, been within the standard of care. ALJ Juárez denied admission of this evidence. He noted that, by seeking admission of this evidence, Cundiff was essentially seeking "to litigate the [Waxman hearing] anew." He noted that Cundiff had not filed an appeal from the ruling issued following the Waxman hearing. Accordingly, the factual bases for the Board's decision to revoke his license were no longer at issue. (*Miller v. Board of Medical Quality Assurance* (1987) 193 Cal.App.3d 1371, 1376–1377.)

Cundiff also offered numerous letters of support, some of which were written prior to revocation of his license and given no weight by ALJ Juárez. Others, which ALJ Juárez did consider, attested to Cundiff's intelligence, honesty and passion for medical research and writing. Conolly, Cundiff's expert witness in the Waxman hearing, also provided a postrevocation letter of support. He supported reinstatement of Cundiff's

license because the decision to discontinue anticoagulants in 1998 "represented a difficult choice between what he described as the 'lesser of two evils,'" and because Cundiff had engaged in significant research and writing in the 12 intervening years, thus demonstrating his dedication to medicine. Cundiff informed ALJ Juárez that, if reinstated, he hoped to obtain "a clinical and teaching position in primary care, internal medicine, and palliative care, preferably at a medical school-affiliated hospital."

ALJ Juárez found that Cundiff failed to demonstrate by the requisite standard of proof of "clear and convincing evidence" to a reasonable medical certainty (*Hippard v. State Bar* (1898) 49 Cal.3d 1084, 1092; *Housman v. Board of Medical Examiners* (1948) 84 Cal.App.2d 308, 315), that he was entitled to reinstatement of his license. The ALJ observed that, in the context of a petition for reinstatement, governing authority permitted him to "consider all activities of the petitioner since the disciplinary action was taken, the offense for which the petitioner was disciplined, the petitioner's activities during the time the certificate was in good standing, and the petitioner's rehabilitative efforts, general reputation for truth, and professional ability." (Bus. & Prof. Code, § 2307, subds. (a), (e).) In addition, ALJ Juárez was required to "evaluate evidence of rehabilitation," by considering the "nature and severity of the act(s)" which led to revocation of the license, evidence of any other acts committed subsequent to the acts which led to revocation which would also constitute grounds for denial of a license, how much time had elapsed since commission of the bad acts and, "[e]vidence, if any of rehabilitation submitted by the applicant." (Cal. Code Regs., title 16, § 1360.2.)

ALJ Juárez noted that Cundiff had not committed any acts which could constitute grounds for revocation of a medical license in the 12 years since his was revoked, as he had not practiced medicine or been otherwise employed in the medical field during that period. Since 1998, Cundiff had devoted his professional efforts to writing two books, and publishing numerous articles, commentaries and letters in peer-reviewed journals, and serving as a peer reviewer himself. He had not undergone any formal continuing

medical education, but stayed abreast of medicine by reading the "health sections" of the Los Angeles and New York Times, and following articles of interest on the internet.

ALJ Juárez found that Cundiff failed to provide sufficient evidence of rehabilitation to merit reinstatement because the nature and severity of the acts which led to revocation of his license were serious, and he was found to have been grossly negligent and incompetent and to have undertaken acts that led to his patient's death. "Saliently," ALJ Juárez observed that "if faced with the same situation today, [Cundiff] would essentially not act differently. Such a steadfast position, in light of the factual findings and conclusions in the [Waxman hearing], leads to the conclusion that the public would be unsafe if [Cundiff's] license were reinstated." The ALJ acknowledged that Cundiff's research and writing demonstrated a passion for medicine. He also noted, however, that the majority of Cundiff's research and writing appeared to have been "single-minded[ly]" focused on his "attempt to establish that his actions in February 1998 were within the standard of care."

At the conclusion of the Juárez hearing, the ALJ issued a proposed decision denying Cundiff's petition for reinstatement of his medical license. The Board issued an order adopting the proposed decision (Order). Cundiff's request for reconsideration of the order was denied.

Petition for writ of mandate

Cundiff filed the instant petition for writ of administrative mandate. Cundiff argued that the order was invalid because (1) ALJ Juárez erred in refusing to admit evidence demonstrating the faulty bases upon which revocation of his license was premised; (2) evidence submitted at the Juárez hearing did not support the ALJ's findings, and ALJ Juárez failed to consider Cundiff's research and writing regarding changes in his opinion and in the standard of care after 1998 for using anticoagulants to treat DVT; and (3) the order was not supported by the findings because the decision to deny reinstatement was based solely on a single controversial medical opinion held by Cundiff. (Code Civ. Proc., §1094.5, subd. (b).)

In his brief in support of his request for a writ of mandate, Cundiff explicitly acknowledged that the doctrine of res judicata barred him from relitigating the facts underlying the September 2000 decision revoking his medical license. Cundiff's contentions were straightforward. He argued that the medical standard of care in California for use of anticoagulants to treat DVT was wrong, that he has done extensive research in the area which demonstrates this and he is an expert in the field, that ALJ Juárez failed to pay his views appropriate deference, and did not properly analyze or consider the evidence at the Juárez hearing.

The trial court rejected Cundiff's contentions. In its tentative ruling on the petition, later adopted in the judgment, the court stated:

"The Board noted that the nature and severity of the acts that led to revocation of Cundiff's license were serious, as he was found to have been grossly negligent and incompetent and his actions led to the patient's death.

"Substantial evidence supports the Board's finding. Despite his protests to the contrary, Cundiff is attempting to litigate the issues from the underlying disciplinary proceeding. The crux of his argument is that his underlying conduct was justified. That issue is foreclosed.

"Specifically, the standard of care as it existed in February 1998 was the relevant medical standard at his revocation hearing. Any evolution of medical thought since that time—whether the result of Cundiff's own articles or not—does not change the fact that Cundiff was grossly negligent in not following a clearly established standard of care in 1998.

"A change in the standard of care might be relevant to the severity of the violation, but Cundiff presented no evidence at the hearing that the standard of care has changed since 1998. . . . Moreover, any changed standard of care for treatment of patients who are alcoholics would be irrelevant since the prior proceeding established that [the patient] was not alcoholic."

DISCUSSION

Cundiff candidly admits that his "primary goal in these proceedings is for the FDA to withdraw the indications for anticoagulant drugs for VTE [venous thromboembolism] treatment." As a secondary goal, Cundiff seeks to have his medical license reinstated, and his professional good name and reputation restored. Here, as in the trial court, Cundiff fundamentally misunderstands the limited nature of the judiciary's role. Whether the federal government should or must consider the research Cundiff and others have performed in the field and, in response, alter the standard of care as to use of anticoagulants is an issue beyond our expertise and jurisdiction. The only issue before us is whether the trial court erred when it denied Cundiff's petition for writ of administrative mandate for failure to make an adequate showing of rehabilitation.

1. Standards of review

On a petition seeking to set aside an agency decision, the pertinent issues before the court are whether the agency proceeded without jurisdiction, whether there was a fair trial, and whether there was a prejudicial abuse of discretion. (Code Civ. Proc., § 1094.5, subd. (b); *Topanga Assn. for a Scenic Community v. County of Los Angeles* (1974) 11 Cal.3d 506, 514–515.) Cundiff insists the order denying his petition for reinstatement of his license was an abuse of discretion. An abuse of discretion is established if the agency did not proceed in the manner required by law, the decision is not supported by the agency's findings, or the findings lack evidentiary support. (*Topanga Assn. for a Scenic Community*, at pp. 514–515; Code Civ. Proc., § 1094.5, subd. (c).) An agency is presumed to have performed its official duties (Evid. Code, § 664), and the petitioner seeking a writ of administrative mandamus bears the burden of proof. (*Alford v. Pierno* (1972) 27 Cal.App.3d 682, 691.) "'"The right to practice one's profession is a fundamental vested right and if a person's license to practice that profession is revoked by an administrative agency, when a petition for a writ of mandate is brought for restoration of the license, the trial court must apply its independent judgment to its review

of the facts underlying the administrative decision. [Citations.]"'" (*Green v. Board of Dental Examiners* (1996) 47 Cal.App.4th 786, 795.)

After a trial court has exercised its independent judgment on the weight of the evidence, we review the record to determine whether its findings are supported by substantial evidence. (*Moran v. Board of Medical Examiners of Calif*. (1948) 32 Cal.2d 301, 308; *Vinson v. Snyder* (1999) 75 Cal.App.4th 182, 186, fn. 3.) All evidentiary conflicts are resolved and all inferences are drawn in favor of the judgment. (*Chatterjee v. Kizer* (1991) 231 Cal.App.3d 1348, 1358.) We review issues of law de novo. (*McLaughlin v. State Bd. of Education* (1999) 75 Cal.App.4th 196, 210; *Conrad v. Medical Bd. of California* (1996) 48 Cal.App.4th 1038, 1045).

2. Cundiff failed to demonstrate an entitlement to reinstatement of his license

The assertions in Cundiff's petition fell primarily into two categories. First, Cundiff argued that evidence should have been admitted at the Juàrez Hearing that would, in his view, have vindicated his decision to terminate anticoagulants for the patient who died in February 1998, thus invalidating the underlying revocation. Second, he argued that his (then) 10 years of research and articles largely aimed at attempting to establish the inefficacy of anticoagulants demonstrated his rehabilitation.

a. Factual issues underlying revocation of Cundiff's license are foreclosed

On the first point, the trial court barred Cundiff from relitigating issues underlying the initial disciplinary proceeding. Notwithstanding his acknowledgement that the factual determinations that gave rise to revocation of his license are barred by res judicata, the crux of Cundiff's arguments at the Juàrez Hearing, before the trial court and, to a lesser extent here, are that his conduct in the case of B.R. was justified. But, as the trial court succinctly stated, "[t]hat issue is foreclosed."

b. Cundiff failed adequately to demonstrate rehabilitation

In a proceeding seeking reinstatement of a professional certificate, the ALJ "hearing the petition may consider all activities of the petitioner since the disciplinary action was taken, the offense for which the petitioner was disciplined, the petitioner's

activities during the time the certificate was in good standing, and the petitioner's rehabilitative efforts, general reputation for truth, and professional ability." (Bus. & Prof. Code, § 2307, subds. (a), (e).) In connection with the petition, the evaluator must consider the nature and severity of the acts under consideration, any evidence of acts committed subsequent to the acts under consideration which also constitute grounds for denial, how much time has elapsed since the commission of the acts, any evidence of rehabilitation submitted by the applicant. (Cal. Code Regs., title 16, § 1360.2, subds. (a)-(c), (e).) We address the pertinent factors in turn.[6]

(1) *Nature and severity of acts*

The acts which led to revocation of Cundiff's license in 2000 were severe. According to the well-established standard of care in the relevant community in 1998, Cundiff was found by ALJ Waxman to have been grossly negligent and incompetent, and to have undertaken actions that led to the his patient's death. Since B.R.'s death, Cundiff appears to have devoted the vast majority of his professional efforts to research and writing aimed largely at establishing that his actions in 1998 were within the standard of care, or that the standard of care has changed since then (or must change). What he fails, and has repeatedly failed, to understand is that the only relevant medical standard at issue in these proceedings was that which was extant in February 1998. As the trial court observed, "[a]ny evolution of medical thought since that time—whether the result of Cundiff's own articles or not—does not change the fact that Cundiff was grossly negligent in not following a clearly established standard of care in 1998." Again, while a change in the standard of care after 1998 might be pertinent to the severity of the violation, Cundiff has never demonstrated that any such change has been effected, only,

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[6] Some of these factors are irrelevant, and need not be discussed. For example, no one questions Cundiff's general reputation for truth, his general ability as a practitioner or the fact that he had an exemplary professional record during the vast majority of time during which his certificate was in good standing.

at most, that he fervently believes such a change is in order and hopes somehow to use this litigation to effect that change.[7]

(2) *Subsequent acts and elapsed time*

By the time of the Juárez Hearing, over 12 years had passed since the acts which gave rise to the revocation of Cundiff's license, and there had been no additional incidents which would have constituted grounds for denial of a medical license. In light of the fact that Cundiff has not been employed in the medical field since B.R.'s death, however, these factors are not significant.

(3) *Rehabilitation*

As the trial court observed, in cases involving requests for reinstatement of a professional license, rehabilitation is a "'state of mind.'" The law looks most favorably on those who have demonstrated """reformation and regeneration,""" once given an opportunity to serve. (*Hightower v. State Bar* (1983) 34 Cal.3d 150, 157.) When seeking reinstatement of a professional license, the petitioner bears a heavy burden to prove a rehabilitated state of mind. (*Hippard v. State Bar*, *supra*, 49 Cal.3d at p. 1091.) He must show by the most clear and convincing evidence that efforts made towards rehabilitation have been successful. (*Id*. at p. 1092.) The more serious the misconduct that led to

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[7] To that end Cundiff devotes a great deal of appellate effort to his assertion that the trial court erred by refusing to read five "all-important" exhibits attached to Cundiff's petition (Exhs. N-Q), which purportedly contain "scientific evidence supporting his changed opinion about the optimal treatment of VTE patient [sic] in the 21st Century."

First, what the trial court actually—and correctly—observed is that it had no duty to review Cundiff's newly designated exhibits "to see if they are in the record." The court is obligated to review the administrative record, plus such additional evidence as may be properly admitted, to determine whether the agency's decision is supported by substantial evidence. (*Eden Hospital Dist. v. Belshe* (1998) 65 Cal.App.4th 908, 915; *Board of Dental Examiners v. Superior Court* (1976) 55 Cal.App.3d 811, 814.) In any event, the point is moot. The "all important" exhibits to which Cundiff refers were part of the administrative record, which the trial court is presumed to have considered in the course of its review. The court did not err by refusing to admit redundant evidence.

license revocation, the stronger the petitioner's showing of rehabilitation must be. (*In re Gossage* (2000) 23 Cal.4th 1080, 1098.) A petitioner's ability fully to acknowledge the wrongfulness of his or her past conduct is pivotal in demonstrating his or her rehabilitation. (*Seide v. Committee of Bar Examiners* (1989) 49 Cal.3d 933, 940.) The evidence is considered in light of the moral shortcomings that resulted in discipline. (*Tardiff v. State B*ar (1980) 27 Cal.3d 395, 403.)

The denial of Cundiff's petition turned on his failure to make an adequate showing of rehabilitation. Cundiff takes issue with this conclusion because he continues to assert, as he has done in each administrative and judicial proceeding initiated since his discharge, that (1) he made no missteps in the medical treatment he provided to B.R. in 1998, (2) evidence should have been admitted that shows B.R. and his family misled hospital staff and, later, adjudicators, about B.R.'s employment and housing history and whether or not he was an alcoholic with liver disease, and (3) over a decade of Cundiff's research focused on the subject of treatment with anticoagulants demonstrates not only that he was correct to discontinue anticoagulant medication for B.R. when he did, but that he should actually never have started anticoagulant therapy for a patient in B.R.'s condition. In the latter instance, the Board's finding that Cundiff would undertake the same action if faced with a future patient in B.R.'s condition was incorrect. Cundiff candidly admits that, in the future, if his license were restored, he would not initiate anticoagulation medications for such a patient *at all*. This, even though there is no showing that the relevant standard of care has changed. As the trial court noted, Cundiff could have supported his petition "by testifying that he would follow [whatever the] standard of care [is] for a patient (such as BR) determined not to be an alcoholic or have liver disease." He was unwilling to do that.

Relying primarily on *Sinaiko v. Superior Court* (2004) 122 Cal.App.4th 1133, Cundiff argues that ALJ Juárez and the trial court erred by failing to recognize his expertise in anticoagulant medicine and to consider his expert testimony regarding changes in the medical science at issue. *Sinaiko* does not advance Cundiff's position.

In *Sinaiko*, the petitioner's medical license was revoked following an administrative finding of 23 instances in which he failed to adhere to the "generally accepted" standard of care regarding the treatment or drug regimen for various allergies and chronic immunologic disorders. The petitioner prescribed drugs not approved for the use by the FDA, and was found to have engaged in improper human experimentation on his patients. (*Sinaiko*, *supra*, 122 Cal.App.4th at pp. 1137–1138.) During a 26-day administrative hearing, medical experts vehemently disagreed regarding whether the petitioner's alternative therapies were within the standard of care. (*Id*. at p. 1141.) The ALJ found all of the experts who testified on petitioner's behalf "'credible in their fields,'" but "'not qualified'" to testify, found the testimony inadmissible under the *Kelly-Frye* rule,[8] and rejected their opinions. (*Sinaiko*, at p. 1139.) The trial court acknowledged the "'glaring error'" between the ALJ's finding that the experts were "'credible'" and its wholesale dismissal of their testimony as "'unqualified,'" but refused to remand the matter. (*Id*. at pp. 1136–1137.) On appeal, the court found that the wholesale disqualification of credible expert witnesses rendered the administrative hearing fundamentally unfair (particularly because the standard of care was obfuscated by *Kelly-Frye* standards of admissibility). (*Sinaiko*, at p. 1137.) As a result, remand was required for a full and fair administrative hearing as to whether the petitioner violated the standard of care. (*Id*. at pp. 1142–1147.)

By contrast, two experts testified as to the standard of care in 1998 for use of anticoagulant medications to treat DVT—Drs. Conolly and Yellin. ALJ Waxman considered the testimony of both experts, but found Yellin the more credible of the two, and fully explained his reasons for that finding. Unlike *Sinaiko* there was no "glaring error" or analytical gap in this case. In 2010, ALJ Juárez explicitly acknowledged

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[8] (See *People v. Kelly* (1976) 17 Cal.3d 24; *Frye v. United States* (D.C.Cir. 1923) 293 F. 1013, 1014, superseded by rule as noted in *Daubert v. Merrell Dow Pharmaceuticals, Inc.* (1993) 509 U.S. 579, 587 [113 S.Ct. 2786, 125 L.Ed.2d 469].)

Cundiff's expertise and stated his intention to consider the evidence of his research and writing, not for its substance, but as it related to his rehabilitation and as a demonstration of his commitment to the advancement of medicine. Cundiff made no showing that the evidence was not considered for that purpose. Neither ALJ Juárez nor the trial court considered the evidence for purposes of Cundiff assertion that the prevailing standard of care should be changed after 2010, nor need they have done so. The issue is Cundiff's willingness to adhere to the prevailing standard of care within the medical community, such that he would not pose a risk to the public if his license were reinstated. Cundiff made no showing by the requisite evidentiary standard that he would do so.

We acknowledge that medical standards evolve over time. That issue, however, is not within our purview. The question is whether substantial evidence supports the trial court's decision to deny Cundiff's petition. On that point we agree with the trial court, and the ALJ's before it that, Cundiff's steadfast insistence, in the face of prevailing medical opinion, that he knows best when it comes to the treatment of venous thromboembolism, and his insistence that he would adhere to his own judgment if permitted to treat future patients, supports the conclusion that a grant of the petition for reinstatement was not warranted. The record contains ample support for the trial court's conclusion that Cundiff failed to present sufficient evidence of rehabilitation to warrant reinstatement. The petition was properly denied.[9]

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[9] The record supports the trial court's conclusion that reinstatement is not warranted because, as a future medical practitioner, Cundiff would be likely to adhere to his own judgment over the prevailing standard of care, at least with regard to patients with DVT and health histories similar to B.R.'s. In medical discipline cases, the "highest priority" is protection of the public. (Bus. & Prof. Code, § 2229, subds. (a) and (c); cf. *Talmo v. Civil Service Com.* (1991) 231 Cal.App.3d 210, 230 ["[t]he 'overriding consideration' in cases of public employee discipline 'is the extent to which the employee's conduct resulted in, or if repeated is likely to result in, "[h]arm to the public service."'"]; *Landau v. Superior Court* (1998) 81 Cal.App.4th 191, 218.) Given the conclusion, reached by two ALJ's and affirmed by the trial court, that Cundiff continues

DISPOSITION

The judgment is affirmed. The Medical Board of California is awarded costs on appeal.

NOT TO BE PUBLISHED.

JOHNSON, J.

We concur:

ROTHSCHILD, Acting P. J.

CHANEY, J.

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to present a public risk, we find no basis for granting the motion to strike. The motion is denied.